Happy New Year! We look forward to continued growth in membership and an expansion of activities for our Section in 2010. We are pleased to report that at last count, our Section had 398 members.

We have been notified by the State Bar that our proposed bylaw changes to expand the council to twenty members has been approved by the Board of Commissioners. The new officers and council members are listed at the end of this Journal. Feel free to contact any of us if you have any questions or suggestions.

Our Section continues to have good exposure, and some of our committees are becoming more active. Steve Fox recently represented our Section at a Thomas M. Cooley Law School Fair in Grand Rapids. Other law schools are contemplating similar events and we expect to have Section representatives at those events as well. In fact, we are forming a Law School Committee to further expand those efforts. Please contact Steve Fox if you are interested in participating.

We also are planning to increase our efforts to track legislative and regulatory matters affecting insurance and indemnity issues, given the current and anticipated proposals which likely will significantly impact the members of this Section. You will see the first Regulatory Report in this issue of the Journal. Contact our Legislative and Regulatory Affairs Committee leaders Marty Brown or Gus Igwe to participate further in those matters.

Our Section also is actively participating in a construction risk management roundtable, presented with the Real Property Law Section on January 14, 2010. The Program Chairs include our Section council members Deborah Hebert and Amy Iannone, and Hal Carroll and Mark Cooper will be leading two of the roundtable discussions, one on additional insured issues and one addressing construction defects and general liability insurance.

The Journal continues to be well received. If you are interested in submitting an article or commentary for publication, contact our editor, Hal Carroll.

As you can see, we have a number of ongoing and upcoming activities and events and welcome your participation.

Timothy F. Casey
The Journal of Insurance and Indemnity Law is a forum for the exchange of information, opinion, and commentary from any perspective on any topic related to the law of insurance and/or indemnity. In addition to being distributed to members, the Journal is also sent to state and federal trial and appellate judges, and selected legislators and members of the executive branch. The Journal welcomes articles or other contributions from any interested person. If you have a proposal for publication, or would like to suggest a topic, please contact the editor, Hal Carroll, at hcarroll@VGpcLAW.com.

New in this issue. For the first time, this issue contains a report of some proposals for regulation in the Office of Insurance and Financial Regulation. We hope to make this a continuing feature of the Journal.

“Insured Contract” Coverage 101

By Noreen L. Slank, Collins, Einhorn, Farrell & Ulanoff, PC, noreen.slank@ceflawyers.com

Your client’s employee, a painter at a construction site, tripped over a wrench left behind by a plumber. She sued the general contractor. She didn't sue your client because the Worker Compensation Disability Act’s exclusive remedy provision prevented that. MCL 418.131(1). The general contractor in turn sued your client for contractual indemnity, attaching a copy of the parties’ “hold harmless” agreement to its third party complaint. You advised your client, correctly, to promptly tender the third party complaint to its Comprehensive General Liability (CGL) insurer as of the date of the accident. That’s when the “occurrence” of “bodily injury” occurred, even though the contract was signed earlier.

Your client wants to know whether its insurer will defend and pay any damages the general contractor is owed under the hold harmless contract. It has been awhile since you looked at this coverage question. Here is a bare bones outline to organize your thinking.

Get a complete copy of the insurance contract from your client, including the Declarations pages. Compare the form numbers on the CGL Declarations page to the numbers on the forms your client supplies to be sure the policy is complete.

Start your review with the general liability coverage form in the policy. It will often be one of the longest forms, spanning something like 23 pages. Exclusion (b) is usually the “Contractual Liability” exclusion, complete with its exception (2). What you will read in a standard Insurance Services Office, Inc. (ISO) policy is that Exclusion (b) excludes all coverage for contractually-assumed liability. Because of exception (2), the Contractual Liability Exclusion (b) does not apply to liability for damages “assumed in a contract or agreement that is an ‘insured contract’ provided the damages occurred subsequent to the execution of the contract or agreement.” Start with the time term. Most insurers believe that “execution” means signing. So check if the hold harmless contract was signed before the painter fell. If it was, you can move to the next phase of the analysis and decide whether the agreement between your client and the general contractor is an “insured contract.” If there is no written contract, or if the contract was signed after the fall, your client is likely going to face coverage problems. But your analysis will show that the insurance policy doesn’t say that the contract had to be in writing to activate the exception. “Execution” doesn’t necessarily mean “signing,” according to Frankenmuth Mutual v Anolick, unpublished opinion of the Court of Appeals, Docket Number 218392,
released March 9, 2001. That case found the “execution” term was satisfied because the injury happened after the insured accepted the job or undertook to perform it.

Next, study the definition of “insured contract.” Your painting contractor client is going to want its hold harmless contract to be an “insured contract.” The “insured contract” definition typically fills more than a page of the policy. You will find a lot of distracting stuff in the definition that likely won’t concern you. You will read about sidetrack agreements (a railroad-related contract), elevator maintenance agreements, obligations to municipalities, easements, licenses, and leases of premises. What you are looking for is usually the longest part of the definition, often part “f.” It typically starts out by saying that the definition of “insured contract” includes “that part of any other contract or agreement pertaining to your business . . . and advertising injury.”

So, first Exclusion (b) takes away all coverage for liability assumed in a contract. Then exception (2) creates an exception for contracts pre-dating the accident if the painting contractor agreed it would assume the general contractor’s tort liability under circumstances allegedly implicated. The general contractor’s liability to the painter is a kind of liability that would be imposed by law, even if there were no contract at issue. It looks like the painting contractor’s CGL insurer owes a defense to the general contractor’s “third party” indemnity claim and coverage.

But, to be confident of that, you need to check if there are other parts of the policy that replace or change any of the core coverage provisions. Typically, look for forms near the end of the policy with names like “broadened coverage” or “contractual liability limitation” or others that reference “contractors” liability. Endorsements must be read together with the policy to understand whether coverage is owed or not. Endorsements may replace or condition the “tort liability of another” section of the definition of “insured contracts.”

For example, an endorsement may change that part of the definition to require that the damages must have been caused in whole or in part by an insured. It may cover “property damage,” but not “bodily injury.” It may not include “personal and advertising injury.” An endorsement may even delete Exception (b) in its entirety.

Your thinking about defense and coverage obligations must be refined by a study of the policy’s endorsements as they interact with and potentially alter the core coverage terms.

One of the most common misunderstandings of exceptions to exclusions is that they have the power to create coverage for an insured. They do not have that power. If a claim falls within an exception to an exclusion, it merely prevents an insurer from relying on the exclusion to defeat its defense or coverage obligations. “Exclusionary clauses limit the scope of coverage provided under an insurance contract; they do not grant coverage.” Hawkeye Security v Vector Construction, 185 Mich App 369, 384 (1990). See also Fresard v Michigan Millers, 414 Mich 686, 697 (1982) where the insured unsuccessfully argued that an exception within the contractual liability exclusion created coverage that could not be undone even though another exclusion applied.


So, if another exclusion applies and precludes all coverage for the general contractor’s claim, your painting contractor client is not going to be owed defense or coverage even though the indemnity agreement initially falls within the “insured contract” exception to Exclusion (b). A typical CGL policy’s Coverage A (for “property damage” and “bodily injury”) is going to have an exclusion that applies to “bodily injury” to an employee. The general contractor’s lawsuit is trying to shift its liability for “bodily injury” it allegedly caused your client’s employee. What prevents the employer’s liability exclusion from trumping the “insured contract” give back under the contractual liability exclusion is that policies typically also have an “insured contract” exception to the employer’s liability exclusion. You will want to check that the exception is intact within the exclusion for “bodily injury” to an employee and that it is not modified by any endorsement.

If a claim falls within an exception to an exclusion, it merely prevents an insurer from relying on the exclusion to defeat its defense or coverage obligations.

To further illustrate that an “insured contract” exception can be trumped by other exclusions, see Vince Gill Tours v THE Ins Co, unpublished opinion per curiam of the Court of Appeals, Docket No. 238351, released March 11, 2003. The City of Saginaw paid the insured’s injured employee’s workers compensation benefits. It sued under an indemnity agreement to recoup those payments. Although the employer liability exclusion has an “insured contract” exception (and so did the contractual exclusion), the exclusion for obligations.

Continued on next page
under workers compensation law had no such exception. That meant coverage was not owed.

Also consider a somewhat more common scenario, which fortunately does not apply to your painting company client. The CGL policy has an “aircraft, auto or watercraft” exclusion. That exclusion has an exception for liability assumed under any “insured contract” for the ownership, maintenance or use of aircraft or watercraft. Typically, the exception does not give back “insured contract” coverage for the ownership, maintenance or use of autos. So, if the painter was run over by the plumber’s car, the auto exclusion would preclude coverage.

To recap: read the policy in all its potentially-applicable parts focusing on the “insured contract” exception to the Contractual Liability Exclusion. Deal with any signing or date issues as to the indemnity contract. Decide if the definition of “insured contract” is satisfied. If it is, the “insured contract” exception to the Contractual Liability Exclusion will be activated (at least initially)—enough to typically require a CGL insurer to defend the complaint. Remember to evaluate the coverage-defeating potential of other exclusions within the policy.

There is a trilogy of indemnities: common law, implied contractual, and express contractual.

Implied contractual indemnity does not fit easily into the pattern of the other two. Common law indemnity is all equity and no contract, a first cousin to contribution. The issue of fault is central to common law indemnity—the indemnitor must be at fault and the indemnitee must be free of active fault. Express contractual indemnity is all contract and no equity. Fault is relevant or not according to the language of the contract.

Implied contractual indemnity lies somewhere between, drawing some principles from each. As with common law indemnity, fault plays a role in implied contractual indemnity; that is, the cases say that the indemnitee must be free of fault. The allegations of the principal complaint are also important, as in common law indemnity, but unlike common law indemnity the allegations of the principal complaint are not controlling as to the existence of fault; the allegations of the putative indemnitee’s third party complaint must also be considered.

Implied contractual indemnity is also vaguely like contractual indemnity because it is, at least in theory, based on a contract. The contract is “implied,” in the sense of “implied in fact,” that is, derived from conduct or words, rather than an express agreement.

This is the way implied contractual indemnity is usually stated:

An implied contract to indemnify arises only if there is a “special relationship between the parties or a course of conduct whereby one party undertakes to perform a certain service and impliedly assures indemnification.”

As with common law indemnity, fault plays a role in implied contractual indemnity; that is, the cases say that the indemnitee must be free of fault.
The court reviewed the issue of indemnity generally, and summarized the various theories that have been applied in other states. It stated that in some cases there is an express contract provision for indemnity, while in others “the contract terms are such that a right of indemnification can be implied.” *Id.* 704. A third category is cases “based on the special relationship between the parties—such as a bailment.” *Id.* 705. A fourth category is the traditional common law indemnity, “based on the theory that the party entitled to indemnification was a ‘passive’ tortfeasor as opposed to the ‘active’ tort of some other party.” *Id.* 705. Ultimately the court concluded that “we prefer to base such right upon the equitable principle that Whiteman was without personal fault . . . .” *Id.* at 706.

*Dale v Whiteman* is best explained as a common law indemnity case, and if the “special relationship,” whatever it is, is sufficient to give rise to implied contractual indemnity, then the indemnity obligation is not an “implied in fact” contract. Still, the phrase “special relationship” has become attached to the theory of implied contractual indemnity, though its function is by no means clear.

Hill *v Sullivan Equipment Co*, 86 Mich App 693; 273 NW2d 527 (1978), leave denied 406 Mich 880 (1979), is the first true implied contractual indemnity case. In *Hill*, an employee was injured by a piece of machinery that lacked a guard. He sued the manufacturer, which had offered a protective cover with the machine. The manufacturer sought indemnity from the employer. The employer had “unqualifiedly rejected [the] proposed protective cover . . . and advised Sullivan that the machine would be situated and used so that it would be inaccessible to workers while in operation.” The court concluded that the employer “may have impliedly agreed to indemnify Sullivan should Sullivan be held liable . . . .” *Hill* at 698.

In *Proctor & Schwartz* *v U S Equipment Co*, 624 F2d 771 (CA 6, 1980), the plaintiff was injured by unguarded equipment. The contract stated that the purchaser would furnish the necessary guards. The court held that this was sufficient to give rise to an implied obligation to indemnify the manufacturer.

In *Swinndelehurst v Resistance Corp*, 110 Mich App 693; 313 NW2d 191 (1981), a General Motors worker was injured by equipment manufactured by Resistance. Resistance sued General Motors for common law and implied contractual indemnity. General Motors conceded that it had altered the machine by removing a “fail safe” system, but argued that it had not rejected a safety device, as had the employer in *Hill, supra*. The court of appeals ruled against Resistance on the issue of fault. The analysis was that if Resistance could avoid liability based on General Motors’ modification, it would not need indemnity, and that if it was found to have been negligent, it would not be free of fault and therefore would be barred from implied contractual indemnity. *Id.* at 700.

. . . if the “special relationship,” whatever it is, is sufficient to give rise to implied contractual indemnity, then the indemnity obligation is not an “implied in fact” contract. Still, the phrase “special relationship” has become attached to the theory of implied contractual indemnity, though its function is by no means clear.

In *Skinner v D-M-E Corporation*, 124 Mich App 580; 335 NW2d 90 (1983) the indemnitee was the seller of an industrial mold and the indemnitor was the company that purchased the mold. The sales contract contained a requirement that the purchaser ensure that safety equipment be used. The contract, in a letter that accompanied the mold, stated:

> It will be the responsibility of American Model to employ proper safety procedures when using the Large Mold Sampler. A suitable face shield, long gloves, protective apron, etc. must be used as safety protection for the operator.

The purchaser did not follow these steps and one of its employees was injured. The court of appeals agreed that common law indemnity was not available because the allegation that the mold was defective would create a right of indemnity only against the manufacturer, not the purchaser. 124 Mich App at 587. However, the court held that the seller did have a claim in implied contractual indemnity against the purchaser, based on the contract requirement. The court drew an analogy to *Hill, supra*, and said that the purchaser “effectively agreed to comply with the specified conditions of sale.” 124 Mich App at 588.

In *Grayson v Chambersburg Engineering Co*, 139 Mich App 456; 362 NW2d 751 (1984), the indemnitee was the manufacturer of a 3,000 pound forging hammer, and the indemnitor was the company that purchased the hammer. In an affidavit and a deposition, an officer of the manufacturer stated that the purchaser expressly represented that it would fabricate the necessary safety wedges to prevent accidental dropping of the hammer. In this case, the representation was allegedly made “several years” after the purchase of the equipment, but the court did not consider this to be fatal to the claim.

These cases, by their facts, describe the reality of the implied contractual indemnity rule. First, the phrase “special relationship” seems not to play any real role in implied contractual indemnity cases. Presumably it means some sort of preexisting legal relationship, such as the bailment in *Dale v Whiteman*, but the cases do not make use of it.

It is the course of conduct that creates the obligation, and the facts of the cases where the rule has been applied describe a
narrow rule: If the purchaser of industrial equipment promises the seller to take steps that will make a guard unnecessary and then fails to take those steps, with the result that the purchase's employee is injured, the purchaser will be required to indemnify the seller against liability resulting from the absence of the guard.

Implied contractual indemnity has long been a theory that is often alleged as part of the indemnity triad, and then forgotten because it never seems to fit the facts of the case. If there is an express indemnity contract, that will be the focus of the litigation. If not, and if the putative indemnitee can show freedom from fault, then common law indemnity will serve the purpose. Implied contractual indemnity is an exotic. It has vitality only in very limited circumstances.

Implied contractual indemnity seems to plod along, applied from time to time, but with little attention paid to the peculiarity of its place in the trilogy. It did receive a bit of attention a few years back, when Justice Markman, dissenting from a denial of an application for leave, said:

would grant leave in this case to consider the relationship between implied contractual indemnity and common-law indemnity, in specific, whether the principle of freedom from fault, as required under traditional understandings of common-law indemnity, should also be required in an action based on implied contractual indemnity even though it is not required for an action based on express contractual indemnity.

Lawrence v Group Admin Agency, 467 Mich 884; 651 NW2d 392 (2002). Nothing came of it though, so implied contractual indemnity is likely to continue to limp along.

Photos from the State Bar of Michigan Annual Meeting

Annual Meeting Speakers: Joanie Schneider, managing director at Marsh and the industry placement leader for Marsh's construction practice; David Yesh, vice president at Marsh; and Amy Hobbs Iannone, deputy general counsel and director of risk management at Barton Mallow.

Section members listen to Annual Meeting speakers.

Outgoing section chair Hal O. Carroll passes the gavel to incoming section chair Timothy F. Casey.

Timothy F. Casey presents outgoing chair Hal O. Carroll with a plaque for his service to the Section as chair.

Save the Dates for the State Bar of Michigan Annual Meeting

September 29- October 1, 2010
DeVos Place, Grand Rapids
ERISA Decisions of Interest

By Michael R. Shpiece, Kitch, Drutchas, Wagner, Valitutti & Sherbrook, Michael.Shpiece@kitch.com

This is the first of a regular summary of court decisions involving ERISA. While this will mostly summarize recent court decisions, it will also give background on key ERISA issues and law. As an introduction, the complexities surrounding ERISA have led various wagts to claim that it really stands for either “Every Ridiculous Idea Since Adam” or “Every Rule Is Somewhat Ambiguous.” The point is these case summaries are simply that -- summaries. The reader is advised that there may be other rules not addressed in the summary that could change the result in other cases.

Most of the cases reviewed will be federal. This is because ERISA provides that most ERISA cases can only be brought in federal court, and those that can be brought in state court are usually removed to federal court. 29 USC 1132.

Sixth Circuit

Statute of Limitations for Bringing Claim for Benefits

Rice v Jefferson Pilot Fin Ins Co, ___ F3d ___ (2009)

Rice was employed and covered under a long term disability policy sponsored by his employer. He claimed that he was disabled, but the carrier denied the claim. After two internal appeals were unsuccessful, he filed suit. While the suit was pending, he and the carrier agreed to remand the case back to the carrier for re-adjudication. The district court agreed, but further ordered that if the case did not settle, either party could reopen the court action by April 30, 2005. The carrier again denied the claim on April 20, 2005 and inexplicably, Rice did not file a new action on June 8, 2007. The question was, was the new action timely.

ERISA does not have an explicit statute of limitations governing benefit claims. Thus, generally, the court will apply the most analogous state statute of limitations. Generally, for cases arising out of Michigan, this has been the six-year general breach of contract statute of limitations. However, the Jefferson Pilot policy had a contractual statute of limitations that required that suit be filed within “three years after proof of loss [was] required to be given.” (This language is required by MCL 500.3422. This case was brought out of Ohio, which presumably has a similar law.)

The Sixth Circuit held that the contractual statute of limitations was upheld, at least if it is reasonable. It also held the contractual provision would be given plain meaning -- that the three year limitation would run from the date Rice was required to file his proof of loss. It rejected both Rice's claim that it should run from the date of the carrier’s last rejection of his claim, and the carrier’s claim that it should run from the date Rice had filed his claim. It also rejected the argument that the pendency of the first action should toll the three years, holding that a dismissal of a suit without prejudice usually does not toll the statute of limitations.

Insolvent Employer, Underfunded Plan, Third Party Administrator Liability

Briscoe v Preferred Health Plan, ___ F3d ___ (2009).

This case involved the unfortunately common occurrence of an employer failing to adequately fund its uninsured health plan, becoming insolvent, and leaving its employees with unpaid medical bills. In this case, the employees looked to the plan’s “third party administrator/claims processor” for help. Although ERISA was based, in part, on trust law, it expanded the group of people responsible for a benefit plan’s operations. It defined this group, “fiduciaries,” to include anybody with discretionary authority over a plan and anybody who has any control over any plan assets (i.e., even if that control is non-discretionary). 29 USC 1002(21)(A). In this case, the plan’s claims processor had “check writing” authority over the plan’s bank account and, in fact, had issued checks of about $10,000 to itself and the employer.

The Sixth Circuit held that this was the limit of the claims processor’s liability. Under ERISA’s definition of “fiduciary,” a person is a fiduciary only “to the extent” the persons qualifies as a fiduciary. There was no evidence that the claims processor was a fiduciary beyond its control of these assets. Specifically, the Sixth Circuit held that the claims processor -- at least in this case -- did not have a general duty to warn the covered participants of their employer’s insolvency. However, that result might be different if the claims processor had additional duties. ■
Regulatory Report

from the Legislative
and Regulatory
Affairs Committee

Under Consideration

By Kathleen Lopilato, Auto Owners Insurance Company

Regulation of Uninsured/Underinsured Motorist Insurance

September 29, 2009: OFIR held a public hearing to consider a regulation pertaining to:

1. Misleading or deceptive UM/UIM endorsements or riders.
2. Unreasonable restrictions or exclusions from coverage.
3. Any experience with an UM/UIM claim fully or partially denied by an insurer.
4. Unreasonable time limitations for filing an UM/UIM claim.
5. A requirement that the insured must file suit and receive payment from the at-fault driver and/or other sources before making an UM/UIM claim or before filing suit against the UM/UIM insurer.
6. A requirement that UM/UIM benefits be reduced or excluded because of benefits received from other sources such as personal injury protection (PIP), liability or health coverage, workers’ compensation, or governmental benefits.
7. A requirement that UM/UIM benefits be offset for unlike types of damages.
8. UM/UIM clauses limiting coverage to persons occupying vehicles and pedestrians, thereby excluding children on bicycles or scooters or anyone else hit by a vehicle while not walking or riding in a vehicle.

Regulation of Independent Medical Exams

Proposed Rule Set 2009-031 LG (Published, Michigan Register June 10, 2009)

Published for comment December 1, 2009
Comment period closed December 18, 2009

If adopted, the regulation will take effect May 1, 2010.

The regulation would apply to “a physical or mental examination . . . at the insurer’s request for the purpose of determining a person’s health or condition as it relates to his or her claim for insurance benefits.”

The physician performing the Independent Medical Examination is required to be licensed in the State of Michigan or another state, have no history of disciplinary action.

The physician performing the Independent Medical Examination is also required to have “the same or a higher level of education, certification, and if applicable, board certification, as the physician or health professional treating the subject of the independent medical examination.”

The physician performing the Independent Medical Examination must also have “devoted a majority of his or her professional time, during the year immediately preceding the date of the examination, to active clinical practice, and/or instruction of students in an accredited health professional school or accredited residency or clinical research program, within the medical specialty most relevant to the subject of the independent medical examination.”


No-Fault Corner

By Ronald M. Sangster, Jr.
Law Office of Ronald M. Sangster, rsangster@sangster-law.com

Supreme Court Activities

In our last issue, we discussed the impact that Justice Hathaway’s election victory over former Chief Justice Clifford Taylor in the November 2008 election, was having throughout the no-fault world. We specifically referenced two cases where the new majority intended to re-examine two key decisions from the Taylor Court – *Kreiner v Fischer*, 471 Mich 109, 683 NW 2d 611 (2004) and *Cameron v ACIA*, 476 Mich 55, 718 NW 2d 784 (2006). We can now add a third case, from the Taylor Court to this list: *Griffith v State Farm*, 472 Mich 521, 697 NW 2d 895 (2005).

Griffith Re-Examined

In *Griffith*, the former majority of the Michigan Supreme Court determined, in the context of food expenses, that items that are just as necessary for an injured person as they are for an uninjured person are not compensable under the No-Fault Insurance Act. In *Griffith*, Plaintiff suffered a severe brain injury as a result of a motor vehicle accident that occurred in 1994. He was confined to a wheelchair and required assistance with basic daily tasks, including eating and bathing. After he returned home, he filed a claim with his no-fault insurer to recover food expenses. Both the trial court and the Court of Appeals determined that State Farm was responsible for paying his ordinary, everyday food expenses, pursuant to the Court of Appeals’ decision in *Reed v Citizens Ins Co*, 198 Mich App 443, 499 NW 2d 22 (1993).

However, in a 4-3 decision, the Michigan Supreme Court reversed and, in doing so, explicitly overruled *Reed*. The court noted that the plaintiff's food costs were not related to the care, recovery or rehabilitation from the injury he suffered in the motor vehicle accident. Although acknowledging that food was necessary for his survival, the majority ruled that, because the food being consumed by plaintiff was no different from the food that everyone requires for sustenance, the food expenses were not compensable.

In *dicta*, the Supreme Court noted that its ruling on the food issue would impact on other items that are considered to be the basic necessities of life. The most significant effect was seen in the area of housing. Claims for room and board expenses were no longer compensable, given the fact that the Michigan Supreme Court, in *Griffith*, explicitly overruled *Reed v Citizens*. See e.g., *Mahle v Titan Insurance Company*, Court of Appeals docket number 277326, unpublished opinion released May 13, 2008.

. . . the former majority of the Michigan Supreme Court determined, in the context of food expenses, that items that are just as necessary for an injured person as they are for an uninjured person are not compensable under the No-Fault Insurance Act.

In *Hoover v Michigan Mutual*, 281 Mich App 617, 761 NW 2d 801 (2008), the Court of Appeals signaled its unhappiness with the Supreme Court's decision in *Griffith*. In fact, the author of the majority opinion, Judge William Murphy, (who, interestingly enough, had authored the opinion in *Reed v Citizens*) urged the Michigan Supreme Court to re-examine *Griffith*. In *Hoover*, the court was dealing with a catastrophically injured individual who required particularized housing needs and around-the-clock care. The opinion itself discusses, at some length, what items are and are not compensable under the Supreme Court’s analysis in *Griffith*.

On September 25, 2009, the Michigan Supreme Court, in a 4-3 decision, granted the plaintiff's application for leave to appeal and specifically ordered the parties to brief whether *Griffith v State Farm* was correctly decided. Justice Young issued a blistering dissent, making note of Chief Justice Kelly’s promise to “undo the damage that the Republican Court has done” from 1999 through 2008, citing her comments in an article appearing in the Detroit Free Press on January 11, 2009. Justice Young also made reference to Chief Justice Kelly's concerns about the application of *stare decisis* when she was in the minority from 1999 to 2008 and remarked that her concerns “pertained only to precedent with which she personally agreed.”

. . . the Court of Appeals signaled its unhappiness with the Supreme Court’s decision in *Griffith*.

Given the philosophical shift of the Supreme Court brought about by Justice Hathaway’s election, we suspect that a number of other 4-3 decisions from the Taylor Court will be re-examined and potentially overruled during the upcoming year.

Continued on next page
Court of Appeals Activities

Court Strictly Applies One-Year-Back Rule to Preclude Recovery of Medical Expenses

Bronson Methodist Hospital v Allstate Ins Co, ___ Mich App ___ (2009)

On November 24, 2009, the Michigan Court of Appeals released its published in Bronson Methodist Hospital v Allstate Ins Co, ___ Mich App ___ (2009) (docket number 286087), which has significant implications for those attorneys dealing with claims involving the Michigan Assigned Claims Facility. In Bronson, one Lemuel Brown was injured in an automobile accident occurring on December 29, 2006. He received medical treatment at Bronson Methodist Hospital. It was later determined that the vehicle Mr. Brown was operating was uninsured, and no insurance was available through his household. Accordingly, on December 14, 2007, sixteen days before the expiration of the one-year notice provision set forth in MCL 500.3145(1), his medical provider, Bronson Methodist Hospital, filed an Application for Benefits with the Michigan Assigned Claims Facility (ACF). The ACF assigned the claim to Allstate Insurance Company on January 7, 2008, and Bronson received notice of the assignment on January 15, 2008. The bill was submitted to Allstate, which refused to pay. Bronson received notice of the assignment on January 15, 2008. The bill was submitted to Allstate, which refused to pay based upon the fact that the One-Year-Back Rule had passed. Suit was filed against Allstate on February 6, 2008.

MCL 500.3174 provides in pertinent part:

“A person claiming through an assigned claims plan shall notify the facility of his claim within the time that would have been allowed for filing an action for personal protection insurance benefits if identifiable coverage applicable to the claim had been in effect. An action by the claimant shall not be commenced more than 30 days after receipt of notice of the assignment or the last date on which the action could have been commenced against an insurer of identifiable coverage applicable to the claim, whichever is later.”

The provider correctly noted that, under this provision, it had until February 15, 2008, to file suit against the assigned insurer. Therefore, its lawsuit, which was filed on February 8, 2008, was timely. Even though the action was timely filed, Allstate Insurance Company, the assigned insurer, argued that the One-Year-Back Rule in MCL 500.3145(1) barred any recovery, because all of the medical expenses at issue had been incurred more than one year back from the date of filing the complaint. In its opinion, the Court of Appeals noted that MCL 500.3174 did not affect the application of the One-Year-Back Rule found in MCL 500.3145(1) to ACF claims because

MCL 500.3174 referenced only the statute of limitations set forth in MCL 500.3145(1) (the one year notice provision), not the damage limitation provision embodied in the One-Year-Back Rule.

Counsel for Bronson Methodist Hospital has indicated that, as of this date, no decision has been made as to whether it intends to file an Application for Leave to Appeal with the Michigan Supreme Court. Given that the Michigan Supreme Court is currently re-examining the key holding in Cameron v ACIA, 476 Mich 55, 718 NW 2d 784 (2006), to the effect that the One-Year-Back Rule is, in fact, a damage limitation provision and not a statute of limitation.

Given this decision, attorneys representing injured parties or their medical providers are strongly advised to file suit against the assigned insurer within one-year from the date of accident. If an insurer has not yet been assigned by the Michigan Assigned Claims Facility, suit can be filed directly against it. When the ACF does assign an insurer, that insurer will be substituted in as a party defendant in the lawsuit.

Court Applies One-Year Contractual Limitations to Preclude Claim for Uninsured Motorist Benefits

In Marshall v Farm Bureau, Court of Appeals docket number 289602, unpublished decision released on November 17, 2009, the Court of Appeals applied a one-year contractual limitations period found in Farm Bureau’s Underinsured Motorist Coverage Provision to preclude a claim for underinsured motorist benefits. The lower court had ruled that this provision was unconscionable, notwithstanding the fact that a similar provision had been upheld by the Supreme Court in Rory v Continental Ins Co, 473 Mich 457, 703 NW2d 23 (2005). However, on appeal, the Court of Appeals reversed, relying upon the Supreme Court’s decision in MacDonald v Farm Bureau Ins Co, 480 Mich 191, 747 NW 2d 811 (2008), McGraw v Farm Bureau, 274 Mich App 98, 731 NW2d 805 (2007) and Gillespie v Farm Bureau, Court of Appeals docket number 268649, unpublished decision released on July 27, 2006. The court specifically noted that...
the one-year limitation contained in the policy provision was, in fact, not unconscionable. The court stated that there was no showing that plaintiff was unable to provide satisfactory notice of the claim within one year. Therefore, the provision was enforceable.

Court Determines that Husband is not an “Owner” of a Motor Vehicle Titled in the Name of His Wife, and Therefore Entitled to Recover PIP Benefits

In the consolidated cases of Spectrum Health v Titan Insurance Company, Court of Appeals docket number 285104 and Zoerman v Titan Insurance Company, Court of Appeals docket number 285105, the Court of Appeals released its unpublished decision on October 20, 2009. The court ruled that the plaintiff was not an “owner” of a motor vehicle titled in the name of his wife that he was operating when he was involved in a motor vehicle accident, as the term “owner” is defined in MCL 500.3101(2)(h)(i), and therefore plaintiff and his medical providers were not precluded from recovering no-fault benefits under MCL 500.3113(b).

In these cases, the vehicle that Zoerman was operating was the only vehicle in the household. It was titled in the name of his wife, Brandy Zoerman, and was uninsured at the time of the occurrence. The vehicle had been in the household for approximately fourteen (14) months. During that time, Plaintiff Zoerman used the vehicle sporadically. Defendant argued that, by virtue of the marital relationship, Plaintiff Zoerman had a “right to use” the motor vehicle titled in his wife’s name, thereby rendering him an “owner” of the vehicle.

The Kent County Circuit Court had granted plaintiff’s motion for directed verdict following the close of defendant’s proofs. The Court of Appeals affirmed the decision of the lower court, finding that Plaintiff Zoerman was, in fact, not an “owner” of his wife’s motor vehicle. The court acknowledged that MCL 500.3101(2)(h)(i) defines the term “owner” as including those individuals “having the use” of a motor vehicle for a period of time greater than thirty (30) days. However, citing Ardt v Titan Insurance Company, 233 Mich App 685, 593 NW 2d 215 (1999), the Court of Appeals ruled that plaintiff was not using the vehicle in a possessory or proprietary manner. The court acknowledged that, under the Supreme Court’s decision in Twichel v MIC General Ins Corp, 469 Mich 524, 676 NW 2d 616 (2004), an individual’s actual use of a vehicle was not relevant. Rather, the court needed to focus on whether the person had a “right to use” the subject vehicle. Later in the opinion, though, the court based its ruling on the fact that because Plaintiff had only sporadic use of the vehicle, and not “regular use” or “exclusive use” of the vehicle, he could not be deemed an “owner” of that vehicle.

An application for leave to appeal to the Michigan Supreme Court has been filed in both cases.

On the Move?

Be sure to change your address with the State Bar of Michigan

In order to safeguard your member information, changes to your member record must be provided in one of the following ways:

1. Login to SBM e-commerce with your login name and password and make the changes online.
   Complete contact information change form and return by fax or mail. Be sure to include your full name and P-number when submitting correspondence.

2. Fax changes to Member Records at (517) 372-1139.

3. Mail changes to:
   State Bar of Michigan
   Attn: Member Records
   306 Townsend Street
   Lansing, MI 48933-2012

Please Note: On September 26, 2001, the Michigan Supreme Court amended Rule 2 of the Rules Concerning the State Bar of Michigan, eliminating the requirement that members of the Bar provide their home addresses to the Bar. Under the amendment, a business address will be sufficient unless it is a mailing address only. Although Rule 2 had included a “residence address” requirement since its inception, the Bar had not requested such information for many years.

Don’t forget to check the website

Important section information, including this newsletter, can be found at http://www.michbar.org/insurance/
Sixth Circuit

Employee and her spouse entitled to AD&D benefits

Kovach v Zurich American Ins Co
___ F3d ___ (6th Cir. 2009)(Case No. 08-4512)
(McKeague, J. dissenting)

Both the majority opinion and the dissent offer a thorough analysis of claims made under an employer-issued accidental death and dismemberment (AD&D) policy governed by ERISA. Claimant – the husband of an employee – was seriously injured in a motorcycle accident while under the influence of alcohol and opiates. The administrator of the Plan denied the claim, concluding that the injuries were not caused by an accident or were otherwise excluded by a provision that disallowed benefits for “purposeful self-inflicted wounds” or for risky behavior such as skydiving, bungee-jumping, etc. The majority disagreed with the administrator’s view “accident” and declined to apply the exclusion. The case was remanded for entry of a judgment in favor of the claimants.

Michigan Supreme Court

Pollution exclusion denied

Auto-Owners Ins Co v Ferwerda Enterprises, Inc
Supreme Court Order of October 9, 2009
(Case No. 138917)

As reported in the April 2009 issue of this Journal, the Court of Appeals found a question of fact about whether a general liability policy covered a claim against Holiday Inn brought by guests overcome in hotel swimming pool area when a cloud of gas escaped during pool repairs. At issue was the pollution exclusion for claims “sustained within a building . . . caused by smoke, fumes, vapor or soot from equipment used to heat a building.” The circuit court found coverage as a matter of law but the Court of Appeals reversed due to questions of fact. By summary order issued October 9, 2009, the Supreme Court reinstated the circuit court's order of summary disposition, holding that “the subject policy unambiguously provided coverage for the defendants’ claims” that they were injured when overcome by a cloud of gas released while a swimming pool was under repair. It remanded to the Court of Appeals for consideration of the attorney fees and penalty interest awarded against Auto-Owners in the trial court.

Michigan Court of Appeals - Published

Pesticide in duct cleaning solution not a “pollutant”

Hastings Mutual Insurance Co v Safety King Incorporated,

Safety King was in the business of cleaning air ducts. It used a sanitizing agent containing small quantities of an antimicrobial pesticide. When Safety King was sued by a customer who claimed injury from exposure to the pesticide, it tendered the complaint to its CGL insurer, Hastings Mutual. Coverage was denied under the pollution exclusion. On appeal, the Court of Appeals rejected the assumption that pesticides automatically fit the CGL definition of a “pollutant” as “irritants or contaminants.” It looked to the dictionary definitions of these terms and concluded that the pesticide used in this sanitizing agent was not a pollutant because it was intended to be present and was not expected to cause harm. The court also observed that if the insurer intended to exclude coverage for claims arising out of the insured’s standard cleaning products, it should have said so in the policy: “Hastings knew or should have known about this normal business practice of using deodorizing and sanitizing agents and would have clearly, specifically, and definitively excluded liability coverage for such practice if that was its intention.”

Life insurer potentially liable for double payment after disbursing benefits to a former spouse with notice of the divorce

Genaw v Genaw
___ Mich App ___ (2009)(Docket No. 284214), lv pending

Unum Life Insurance Company was not automatically protected under MCL 552.101(2) from paying life insurance benefits to the estate after disbursing benefits to the former wife. Unum had notice of the divorce when it paid the benefits. This notice required it to “investigate further before remitting payment of the benefits to the designated beneficiary.” The protection against double liability afforded under MCL 552.101(2) applies only where the insurer “does not receive
written notice of a claim and a divorce.” Here, Unum had notice of the divorce. The decision of the Court was split, however, and the majority agreed that the statute “may prove to be more confusing than helpful to insurance companies” in deciding the proper recipient of benefits because it makes the determination “highly dependent on factual circumstances unique to each case.”

UM benefits potentially available after default judgment is set aside


The insured sued an uninsured driver responsible for her injuries and, without the consent of her Uninsured Motorist insurer, obtained a default judgment. Her UM policy excluded coverage for judgments prosecuted to judgment without the insurer’s knowledge and consent. Upon learning this, the insured set aside the default judgment and pursued her UM claim. The court held this was permissible. “[W]e hold that where an insurance policy contains an exclusionary provision that is triggered upon settlement or judgment without the knowledge and consent of the insurer, if the default judgment or settlement is set aside such that an insurer retains its right of subrogation, the exclusion does not apply.”

Michigan Court of Appeals - Unpublished

Professional liability coverage promised by employment contract

Wognicki v Warren Geriatric Village, Inc, Unpublished per curiam opinion of the Court of Appeals, Issued October 15, 2009 (Docket No. 286783), lv pending

A primary care physician’s employer promised “to provide professional liability insurance in the amount of $100,000/$300,000 to the employed physician.” The physician applied for and received the insurance under a claims-made policy with limits of $100,000/$300,000, paid for by the medical practice. After the physician left the practice, her coverage was cancelled. The insurer offered tail coverage, but she declined. When the physician was later sued by a patient treated during her employment, the physician filed a third party complaint against her former employer, claiming that it was obligated under her employment contract to provide her with insurance against the lawsuit. The employer argued that the employment contract did not specify whether the coverage was to be “claims made” or occurrence-based, but the court held that the employment agreement unambiguously promised to insure the employee physician for acts during employment and, therefore, the type of policy purchased (claims made or occurrence) was irrelevant. The court also rejected laches and estoppel as defenses to coverage.

Defective workmanship, standing alone, is not an occurrence

Hometown Building Company, LLC v North American Specialty Insurance Co, Unpublished per curiam opinion of the Court of Appeals Issued October 13, 2009 (Docket No. 287336)

This is a coverage dispute under a commercial general liability (CGL) policy issued to a homebuilder. The insured built a residence and was later sued by the homeowners for problems related to water incursion, i.e., physical damage to the structure and mold damage to personal property. The homebuilder tendered the complaint to its two CGL insurers, one of which was Amerisure. Amerisure denied coverage based upon various exclusions, including the mold exclusion. The court followed Hawkeye and held that defective workmanship, standing alone, does not constitute an “occurrence.” Only if defective workmanship results in damage to persons or property other than the work itself will an “occurrence” be found. Since damage to the physical structure was damage to the insured’s own work, there was no occurrence and thus no coverage for that claim. And the mold damage to the personal property was specifically excluded under the Fungi or Bacterial endorsement exclusion.

Umbrella policy rescinded due to misrepresentation

Citizens Ins Co of America v Rippy Unpublished per curiam of the Court of Appeals, Issued September 17, 2009 (Docket No. 284510), lv pending

The insured’s failure to inform umbrella insurer that her elderly mother was a member of her household was grounds for rescinding the policy when a claim was made as a result of the mother’s liability for an auto accident. The insured misrepresented the members of the household in the original application and in subsequent renewal questionnaires, which

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Significant Insurance Decisions  
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were relied on by the insurer in issuing the policy and in determining premiums. The Court refused to find the insurer responsible based on the mistakes of the agency.

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Property insurance – vandalism coverage and earth movement exclusion

*Acorn Investment Co v Michigan Basic Property Ins Assc*
Unpublished per curiam of the Court of Appeals,  
Issued September 15, 2009 (Docket No. 284234)

Damage caused by the theft of fixtures from rental property once the tenant vacated was a “covered peril” (vandalism). But coverage for damage to the basement walls was lost under the “earth movement” exclusion because “the failure of the basement walls was caused by or resulted from lateral earth pressure.” This was damage caused by “shifting, expanding or contracting” earth and was thus excluded.

Shooting not an “occurrence”

*Liberty Mutual Fire Ins Co v Stoutenburg*
Unpublished per curiam of the Court of Appeals,  
Issued September 3, 2009 (Docket No. 286106)

The insured homeowner, in an altercation with an acquaintance, retrieved his shotgun and fired it into the ground intending to drive him off the property. The bullet ricocheted off the floor and struck the acquaintance in the knee. After pleading guilty to intentional discharge of a firearm, the insured looked to his homeowners insurer for a defense and coverage when the acquaintance filed suit. The Court of Appeals found the insured judicially estopped from claiming “that the firing of the gun was accidental.” And the court distinguished the case from *McCarn*, not only because the insured did not believe the gun was loaded and only intentionally “pulled the trigger.” Here, the insured intentionally “discharged” the gun, which “means the actor necessarily intended to fire and not merely pull the trigger.” The insured “would have expected the consequences of his actions — namely, that firing a gun near another individual’s feet in a small, enclosed room would create a substantial risk that an injury may result.”

No bad faith claim for failure to pay

*Nixon v Farm Bureau Ins Co*
Unpublished per curiam of the Court of Appeals  
Issued October 1, 2009 (Docket No. 285343), lv pending

Trial court erred in denying summary disposition on bad faith claim for failure to pay property damage claim due to suspected arson. “Michigan courts have held that breach of an insurance contract can support an independent tort claim only if the plaintiff alleges wrongdoing beyond the mere failure to pay insurance benefits.” Michigan, in other words, refuses to recognize “the tort of bad-faith refusal to pay an insurance claim.”

Untimely E&O claim

*Auto-Owners Ins Co v Lloyds London*
Unpublished per curiam of the Court of Appeals  
Issued September 17, 2009 (Docket No. 287396)

Claim made outside the “claims period” on a “claims made” errors and omission policy is not covered.

Untimely UM claims

*Idalski v State Farm Mut Ins Co*
Unpublished per curiam of the Court of Appeals  
Issued September 29, 2009 (Docket No. 287279), lv pending  
and  
*Marshall v Farm Bureau Gen’l Ins Co of Michigan*
Unpublished per curiam of the Court of Appeals  
Issued November 17, 2009 (Docket No. 289602)

Uninsured Motorist claims filed outside the one-year contractual limitations period are too late. Prejudice to the insurer is not a consideration. ■
Insurance & Indemnity Law Section
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